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THE HUNTERIAN LECTURES

ON

THE PATHOLOGY AND SURGERY OF INTUSSUSCEPTION.

Delivered at the Royal College of Surgeons of England.

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LECTURE III.—THE TREATMENT OF INTUSSUSCEPTION.

I CALLED your attention, Sir, in my previous lectures to the scientific aspects of intussusception, and I have now to deal with the subject from a practical standpoint. I showed you first the minute anatomical changes which take place in the tissues injured by invagination, and afterwards I brought before you certain anatomical, physiological, and pathological factors which appeared to be of importance in causing the affection. These points are only of subordinate interest to the practical surgeon, for though a knowledge of them helps to elucidate the cause of intussusception, it does not in any way assist in its cure.

Turning, then, from the theoretical to the more severely practical aspects of intussusception, there can be no doubt that all cases of the affection have to be treated upon the assumption that they are either reducible or irreducible. I do not propose to occupy your time with a history of the treatment of intussusception. Those who are interested in such matters—and every surgeon ought to be, for the practice of surgery is part of a liberal education, and is not the mind-narrowing vocation that some would have us believe—will find that Professor Ashhurst,¹ Dr. Leichtenstern,² and Mr. Jonathan Hutchinson³ have published admirable summaries of it from different points of view.

It is still necessary, however, to teach the majority of mothers that early advice and abstention from domestic remedies are required in all cases of painful constipation occurring suddenly in young children, just as it is only lately that men as well as women have come to understand that the immediate treatment of strangulated hernia means recovery, whilst to delay is death.

a. REDUCIBLE INTUSSUSCEPTION.

Clinical and pathological evidence show that an invaginated portion of the intestine has a constant tendency to reduce itself until its muscular coat becomes paralysed, or adhesions are formed at its neck. This tendency to reduction is probably counteracted during the earlier stages of an intussusception by the tonic contraction of the ensheathing bowel, for if this be reduced or abolished by mechanical or other means the intussusception can be easily reduced until hardly any invagination remains. Complete reduction is not easy, for the congestion and consequent œdema of the muscular coat at the apex of the intussusception render this the hardest part of the surgeon's task. Inflation or injection of the large intestine is therefore upon the whole the safest

and the most satisfactory treatment for all cases of uncomplicated intussusception, provided that the patient has been seen early enough, that the distending force be applied gradually, and that it be not too great.

1. TREATMENT BY IRRIGATION.

Injection is preferable to inflation, because the force employed can be graduated with much greater accuracy, whilst the apparatus is always at hand. But irrigation is not of the least service in the enteric form of intussusception—where one part of the small intestine is invaginated into another, for many observers⁴ have shown by experiments on living and on dead bodies that fluid can only be made to pass through the ileo-cæcal valve when over-distension of the colon has caused a mechanical separation of its two segments. Such an over-distension, however, is in the highest degree dangerous, because it is usually accompanied by a cracking of the serous coat of the large intestine, which is soon followed by rupture of the muscular and mucous layers if the force be continued.

Professor Senn⁵ thinks that somewhat better results may be obtained in cases of enteric intussusception by distending the intestine with such a gas as hydrogen, for he finds that a gas passes through the ileo-cæcal valve under a much lower pressure than a fluid. But enteric intussusceptions are both rare and difficult to recognise, and it is better to open the abdomen at once in every case where this condition is suspected.

The method of irrigation under hydrostatic pressure is the most satisfactory way of distending the colon in cases of colocolic and ileo-cæcal intussusception. The fluid is allowed to pass into the large intestine by its own weight, so that the force can be accurately estimated by observing the height to which the reservoir is raised above the recumbent body of the patient. The valuable experiments of Mr. Mortimer⁶ in London and of Mr. Mole⁷ in Bristol have greatly increased our scientific knowledge of the effects of irrigation in the treatment of intussusception. They have shown that the results depend partly upon the obstruction to be overcome within the intestine and partly upon the external support. The greater the pressure within the abdomen the more is the distending force neutralised, for the intestinal wall is then compressed between two opposing forces. Mr. Mortimer experimenting upon the unopened bodies of children, points out that in an irreducible intussusception the large intestine is distended by almost the whole force of the stream when the abdominal walls are lax, as is usual in children under chloroform, and when there is not much tympanites. The intestine may kink if fluid be allowed to enter the bowel too suddenly or too forcibly, and the distending force is then prevented from acting upon the intussusception, so that the colon may become sufficiently overdistended to rupture. A similar accident may happen as a result of a sudden peristaltic contraction taking place whilst the pressure is being applied. There is apt to be cracking of the serous coat of the large intestine when the resultant pressure of the fluid distending the colon is about 2½ lbs.—that is to say, when the irrigator is raised 5 feet above the body of the patient, and this accident usually happens when the irrigator is raised to 8 feet, though the bowel may be completely ruptured when the reservoir is only raised to a height of 6 feet.

Mr. Mole used a slightly different method of experiment, but he arrived at substantially the same results, and, as he worked with the abdomen open, he was able to see the exact manner in which the intestine ruptured as a result of its overdistension. When this accident is imminent the peritoneal coat of the bowel splits longitudinally for a considerable length; the fluid then begins to leak through the wall of the gut, a small jet issues, and at last, if the pressure be continued, a large rent takes place, with forcible expulsion of the contents of the bowel into the peritoneal cavity.

Rupture of the large intestine is most likely to occur in the transverse colon, at or near to the splenic flexure, whilst in the small intestine it takes place in the unprotected portion of the bowel which is situated between the two layers of the mesentery.

It should be borne in mind, however, that these results are derived from experiments upon dead bodies and upon

animals. It is impossible for the surgeon to estimate the capacity of the colon in any individual case of intussusception, nor can he judge the amount of pressure that may be applied with safety to the inflamed and softened intestinal wall at the neck of the tumour. A pint of fluid was sufficient to rupture the bowel in a child,⁹ aged 3 months, though the injection was made by one of the most careful and experienced surgeons in the profession; whilst in another child,¹⁰ aged 7½ months, three quarts under a head of 5 feet pressure were injected into the intestinal canal without doing any injury.

Dr. Muir, at my instigation, has measured the capacity of the colon in the bodies of several children, with the results shown in the table I presented to you in my second lecture. The measurements show how widely different is the capacity of the colon in different children of almost the same age. Thus in a male child of 5 months old, 10 ounces of water were sufficient to distend the colon, whilst in a girl of 7 months 30 ounces could easily be passed into the large intestine.

Forty-eight hours is the limit of time within which irrigation is likely to be successful in an ordinary case of ileo-cæcal intussusception with tolerably acute symptoms, and such pressure is alone justifiable, in a child of 2 years old, as can be obtained by raising a reservoir of water containing a quart of salt solution at 100° F. 2½ feet above the anæsthetised patient. I do not think that inversion of the patient renders irrigation more successful, but I am satisfied that long-continued distension under a low pressure is of more avail than rapid dilatation under a high pressure. The surgeon should keep one hand flat upon the abdomen whilst irrigation is being performed, and he must carefully avoid great variations of pressure. A sudden and uniform enlargement of the whole abdomen during irrigation raises a strong suspicion that the bowel has been ruptured, because rupture of the colon almost always takes place before there is any great distension of the small intestine. A laparotomy must be done at once when this accident happens, and the seat of rupture should be looked for either on the left side of the abdomen or at the neck of the intussusception.

The length of the intussusception is no bar to its reduction by irrigation, for many cases are recorded in which an intussusception has been reduced even when the ileo-cæcal valve has protruded beyond the anus, and Dr. Mansel Symptom¹¹ recently cured a case by this means when 6 inches of the intestine were visible externally. This is not difficult to understand by the light of the anatomical facts brought to your notice in the last lecture. The progress of a very large intussusception is usually rapid, for the colon is disproportionately wide, and the mesentery is either unduly long or peculiarly extensible. A rapid advance presupposes, therefore, an easy reduction, and such large intussusceptions often unfold themselves spontaneously when their reduction has been once begun.

A chronic case with a great deal of glairy discharge, whose onset has been heralded by similar attacks of less intensity, may be treated by irrigation after a very much longer time than is allowable in ordinary cases; indeed some cases¹² of this nature have been cured when the symptoms have lasted from four to six months. The duration of the symptoms is perhaps always of less importance in an intussusception than their intensity, for a long-standing intussusception is often more easily reduced by irrigation than one of comparatively short duration. The longer the time the symptoms have lasted, however, the more likely it is that adhesions will have been formed. Slight adhesions are not an insurmountable barrier to reduction by irrigation, though they militate greatly against its success. Professor Senn¹³ investigated this point, and found that in one case when the colon was overdilated the adhesions which had formed round an artificial invagination made three days previously gave way with an audible sound, and the intussusception was completely reduced; but the force required to overcome the adhesions ruptured the serous coat of the intestine in three different places, and the animal died on the following day with diffuse peritonitis. He was more successful in another experiment, for the intussusception was reduced without any injury to the walls of the bowel, and the animal survived the operation.

Abundant hæmorrhage would seem to contraindicate any

attempt to reduce the intussusception by irrigation. Much extravasation of blood implies destruction of the muscularis mucosæ, infiltration of the submucous tissue, cedema of the circular muscle, and consequently a swollen condition of the mucous and submucous layers, with paralysis of the muscular coat. The swollen tissues render reduction difficult, and if the intussusception be reduced the paralysis of the muscle allows recurrence to take place, and may thus lead to the loss of much valuable time. Absence of hæmorrhage, on the other hand, associated with severe collapse, equally contraindicates the treatment of intussusception by irrigation, for it points to the early recurrence of gangrene.

A great disadvantage attends the use of irrigation for the cure of intussusception apart from the danger of rupture, which has already been sufficiently discussed. This disadvantage is the liability to recurrence after reduction. Dr. F. H. Elliott¹⁴ has published the details of a case of recovery from intussusception in a child, aged 8 weeks, in whom recurrence took place twenty-four hours after the first reduction, five days after the second reduction, and thirteen days after the third reduction. Dr. Chaffey¹⁵ had a less satisfactory experience, for an intussusception recurred on five separate occasions until the patient—a boy aged 3 years—died of exhaustion. When recurrence is a very marked feature in a case, it is better to open the abdomen at once rather than to trust to repeated irrigation of the bowel, for it appears¹⁶ that reinvagination can positively be prevented by shortening the mesentery at the point of invagination by folding it upon itself in a direction parallel to the bowel, and maintaining it in this position by a few catgut sutures. No absolute rule can be laid down, however, for a child is now under my care who apparently has been cured of an intussusception, though irrigation had to be done on five separate occasions before the tendency to recurrence was overcome.

There appear to be several reasons for this tendency to recurrence. The first and the least satisfactory is that the conditions which led to the original intussusception may persist. An intussusception would then recur after any method of treatment, but it is particularly likely to do so when the reduction has been brought about by distension of the large intestine. A rapid distension of the colon followed by its sudden emptying are exactly the conditions which lead to increased peristalsis of its active and as yet uninjured walls. All methods of treating intussusception by dilatation of the bowel are therefore open to the objection that they predispose to a fresh invagination of the congested, compressed, and partially paralysed portion of intestine which has just been released. A second objection to this method of treatment lies in the fact that the operator cannot see what he is doing, and that it is necessarily performed with uncertain guides. The reduction is therefore incomplete in some cases, for the last part of an intussusception is the most difficult to unfold, and in practice when the tumour has disappeared as a result of irrigation the operator is usually chary of continuing the process, and he is quite content to allow the fluid to escape as soon as possible. Cases are well known in which such an incomplete reduction has been found at the necropsy. Dr. Goodhart¹⁷ records one where a local cedema of the submucous tissue, with a slight invagination of all the coats of a part of the cæcum, remained after an intussusception had been reduced by inflation. He thought that the invagination was sufficient to start a fresh intussusception, though he confesses that it is more likely that the swelling would have subsided if the patient had lived a longer time. Professor Greig Smith¹⁸ also quotes a case in which the appendix was found unreduced after death, and still invaginated within the cæcum. The ileo-cæcal valve, too, is sometimes a cause of trouble after the reduction of an intussusception, theoretically because a hæmorrhage into its substance may make its segments gape, or may so stiffen them as to predispose to a fresh invagination of the ileum, practically because it may be mistaken in its inflamed state for the tumour of an intussusception. This mistake has been made more than once, and on one occasion¹⁹ it led the surgeon to open the abdomen of a child, aged 6 months, in the full belief that a previous irrigation had failed to reduce the whole intussusception.

The after-treatment of an intussusception which has been

cured by irrigation must consist in keeping the patient absolutely at rest, in the administration of opiates, and in feeling the abdomen gently from time to time to ascertain that the tumour has not recurred.

2. TREATMENT BY ABDOMINAL SECTION.

When irrigation has failed to relieve an intussusception, the method must not be continued for too long a time, because the patient may become collapsed, even though no injury be done to the bowel. Abdominal section must then be performed at once, and this forms the second great method of treating intussusception. The failure of irrigation, because it leads to the necessity for laparotomy, increases the surgical interest of the case tenfold, but unfortunately it adds greatly to its gravity: for whilst the mortality of intussusception in infants treated without operation is calculated in the latest series of tables at 59 per cent., the mortality amongst the cases in which the abdomen had been opened is 67.2 per cent. Dr. Wiggin,²⁰ who appears to have compiled these statistics with great care, explains that this high rate of mortality is due to the inclusion in his tables of all cases in which laparotomy has been performed. The risk of abdominal section is reduced to 22.2 per cent., if only those cases be reckoned which have been operated upon within forty-eight hours of the onset of the symptoms, and if we only take into account the cases which have been submitted to operation since the year 1889, when the more perfect technique of abdominal surgery has become generally known. Such an estimate, however, is based necessarily upon published cases, and therefore upon a comparatively small number, and it is probably inaccurate, for no record has been kept of many unsuccessful operations.

The surgical interest of the case is heightened by the failure of irrigation to relieve an intussusception, for the curiosity of the operator is piqued to know what he will find. Irrigation fails to relieve the invagination in some simple cases, even when no adhesions are present; in others, slight adhesions at the neck of a simple invagination prevent its reduction, whilst it may be that the case is so complicated as to need the whole of his ingenuity, first to find an appropriate method of treatment, and afterwards to carry it on to a successful issue.

Shock is the great and immediate cause of danger in every case of abdominal section performed upon a young child for the relief of an intussusception, whether the invagination be simple or complex. Chilling of the body, bleeding and powerful nerve stimuli ascending to the spinal cord from the splanchnic region, are the causes of shock, and they should be reduced to a minimum. Chilling of the body is easily prevented by placing the patient upon a hot-water bed, and by swathing his arms and legs in cotton-wool, whilst the chest is covered with a roughly-made jacket of Gamgee tissue. The subcutaneous injection of one-fiftieth of a grain of strychnine, with enemata of brandy and hot water, will cause a temporary rally lasting long enough for a simple abdominal section to replace a piece of invaginated intestine in a child, though in a long operation these measures must be repeated more than once. The anæsthetic should be given sparingly. The incision should be made in the middle line, and at first it should only be long enough to admit two fingers and a thumb into the peritoneal cavity, for in the simplest cases it is unnecessary to drag the intestine to the wound. Indeed, it is better not to do so, because such a proceeding stretches the mesentery, and so stimulates the nerves that the splanchnic vessels are first contracted and afterwards dilated, leading to as great a lowering of blood pressure as would be caused by a very serious hæmorrhage. The less the intestine is handled, therefore, the better it will be for the patient, and an intussusception can often be reduced by squeezing it gently from below upwards. But it is much better to enlarge the incision and to bring the tumour into view if there is any difficulty in reducing the intussusception rather than to run any risk of tearing the serous coat by manipulating the intestine in too cramped a space. All goes well in the simplest cases, that is to say, in those which have been seen sufficiently early and in which the invagination, though too tight to be reduced by irrigation, is still easily reduced by a minimum of manipulation. In these cases it is only necessary to replace the invaginated intestine

and to suture the abdominal wound to ensure the recovery of the patient. Rapidity combined with caution is the golden rule in all cases of abdominal surgery, and if it be followed in these cases the operation of laparotomy, even in a young child, is no more dangerous than is the ordinary operation for the relief of a strangulated hernia in an adult. The mortality rate of 22.2 per cent. applies more especially to this class of cases, and though it is still far too high, we may hope that as time proceeds and the cases are seen earlier, it will be still further and very greatly lowered.

Great care must be taken, even in the simplest cases, to prevent any cracking of the serous coat of the bowel during the reduction of an intussusception. This injury is always repaired by plastic inflammation, which is too often the starting point of a diffuse suppurative peritonitis, or if this danger be escaped it leads to the formation of adhesions which unite one coil of gut to another. Professor Senn²¹ recognised the gravity of the accident when he recommended that the injured part of the bowel should be covered with a strip cut from the omentum and sutured round the intestine, so that its end should project just beyond the mesenteric border. A certain amount of danger, too, attends the last part of the reduction of an intussusception lest too great or too injudicious an exercise of force should tear the bowel at the neck of the tumour, where the tissues have become softened by inflammatory changes, for such an occurrence may require the instant performance of some form of enterectomy. Washing out the peritoneal cavity is wholly unnecessary in the simpler cases; it lengthens the operation and increases the shock without yielding any adequate result.

Even when a simple intussusception has been cured, and the surgeon has satisfied himself that he has done all that it is possible for him to do, a final difficulty may arise in replacing the inflated intestines within the peritoneal cavity. This difficulty is very commonly met with in children, and it may require that the originally small incision in the abdominal wall should be greatly enlarged, for less harm will be done by squeezing the distended intestines through a large hole than through a small one. The intestines sometimes have to be punctured in several places before they can be replaced, but I am always a little doubtful of the wisdom of such a proceeding, for the distension is great, the holes are small, and the kinks are numerous, so that it is not possible to produce any very great reduction by this method; besides the gas is produced within the intestine, and is formed very rapidly. Additional care must be taken in suturing the wound when the intestines are much distended, for it is quite easy to kill the patient by passing one of the sutures through the distended gut, an accident which is especially likely to happen in closing the angles of the abdominal wound.

An intussusception sometimes recurs after it has been reduced, but recurrence is less usual after an abdominal section has been done than when reduction has been brought about by irrigation. In a few cases²² the intestine has remained so oedematous that the tumour has been felt even after the wound has been closed, leading the operator to suppose that invagination had recurred. Such a condition may be distinguished from true recurrence by the fact that the swelling rapidly disappears, and with it the symptoms of obstruction. This is a rare accident, but Mr. Pearce Gould met with a rarer one when he had to perform a laparotomy twice at an interval of three months for the reduction of two separate intussusceptions in the same patient. There is another condition which is equally uncommon in which after an abdominal section has been done and the intussusception has been reduced, the patient passes one or two healthy motions, and seems to be on the highway to recovery, but within a few hours or a few days he again becomes constipated, his belly becomes distended with flatus and he dies. A case of this kind recently came²³ under my care in the person of a boy aged 8 months who had suffered thirteen and a-half hours from symptoms of intussusception. Irrigation failed to reduce the intussusception, so I opened the abdomen and easily replaced the bowel without doing it any injury. The child afterwards passed two motions, one blood-stained the other natural, and took his food well, digesting it. Forty-five hours after the operation he began to vomit, the in-

testes became distended, and he died with all the symptoms of intestinal obstruction. The examination of the body in the post-mortem room showed that the intestines were distended with flatus to within a foot of the ileo-cæcal valve. The distension stopped suddenly, although there was no visible cause for its arrest either outside or within the intestine or abdomen. The colon, like the lower part of the ileum, was collapsed. There was no intussusception and no peritonitis. A similar case is recorded by Mr. Pick.²⁴ Brun's case recorded by Müller²⁵ seems to have been of a similar kind. It occurred in a boy aged 12 years, who died on the ninth day after excision of a piece of the small intestine for the cure of a chronic irreducible intussusception of the ascending colon, associated with a retrograde but reducible invagination of the upper part of the descending colon. The intestinal wound was found to be soundly healed after death, but the stomach and small intestines were greatly distended with flatus without any apparent cause.

The histological appearances to which your attention has been called already show that the bowel in these cases is paralysed at the seat of invagination, for it is sufficiently injured to destroy its functional activity, but not badly enough to destroy its vitality. If a similar case should unfortunately happen again in my practice, I shall inject hypodermically a grain or two of barium chloride in solution. The drug is a powerful stimulant of peristalsis, but its action is less severe than eserine. Either drug should be serviceable, for it is only in rare and advanced cases of intussusception that both the circular and longitudinal layers of muscle are involved; in the early stages one layer is injured more seriously than the other, and the circular layer more often than the longitudinal.

When an intussusception has been successfully reduced after laparotomy, the surgeon should satisfy himself before he closes the abdomen that he has overcome the only cause of obstruction, and that the case he is treating is really as simple as it appears to be, for an intussusception may be complicated by a variety of troublesome and dangerous conditions. Dr. Handfield Jones and Mr. Page²⁶ published the details of such a complicated case in which there were two intussusceptions of the colon and one of the ordinary ileo-colic type in a boy aged 5 years, and I have already mentioned the less uncommon cases of double intussusceptions. Double intussusceptions usually run in opposite directions, and are separated by an interval of healthy intestine, but occasionally²⁷ they may overlap each other so that the retrograde invagination, which is generally the distal one, has to be reduced before the upper one can be released.

Another complicated case, coming under the care of Dr. Whipham and Mr. Turner,²⁸ occurred in a woman aged 29, in whom an intussusception associated with a polypus was complicated with a volvulus at two different parts of the intestine. In yet another case—occurring in a girl of six months old—recorded by Mr. Clinton Dent,⁴ a double intussusception, ileo-colic as well as ileo-cæcal, was still further complicated by an internal hernia which was apparently secondary. The hernia was strangulated by the sharp edge of a fold of mesentery attached to the ileum, and it was buried deeply in the cavity of the pelvis.

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(To be continued.)

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A CASE OF SUPRAPUBIC PROSTATECTOMY, WITH THE SUBSEQUENT HISTORY OF THE PATIENT.

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THE appearance of the patient whose case is related below as he stepped into my consulting room after an interval of ten months, when from being a thin, feeble, decrepit old man, he had changed to a healthy-looking, brisk, and vigorous adult, suggested to me the propriety of reporting his case. I am indebted to my friend, Dr. H. Colligan Donald, who assisted me with the operation, for the notes.

D. J., aged 61, a saddler, was sent to me by Dr. Mitchell, of Topcliffe, in October, 1894, complaining of painful and difficult micturition. He gave the following history: About two years previously, that is, in 1892, he first experienced difficulty and pain in micturition, and after the act he passed involuntarily a few drops of water, wetting his dress. Soon after this he experienced a desire when in bed to pass water, compelling him to get up two or three times nightly. Before this, for some years, he had had to get up in the night once or twice, but he had thought nothing of this, as he was otherwise well. This feeling was always more pronounced and accompanied by pain if he had been exposed to fatigue or jolting of any kind during the day. Six months previous to my seeing him he developed cystitis, and passed a considerable quantity of blood with the urine, noticeably after the use of the catheter. One month before I saw him he had complete retention of urine, which was relieved by a large-sized soft catheter. Since then he had required to use the catheter from day to day, the frequency of micturition increasing. His general condition had always been good, and he had always led a temperate life, but owing to the suffering and distress during the day, and the frequent disturbances at night, he had become thin and looked very ill.

On examination I passed without difficulty a No. 12 catheter, drawing off $4\frac{1}{2}$ ounces of residual urine. The sound failed to detect the presence of a stone, but the walls of the bladder felt roughened. The prostate as felt by the rectum was found to be enlarged, but not tender. Urine, alkaline, 1020, trace of albumen, no sugar, thick white deposit, which a microscopic examination showed to be composed of pus and phosphate of ammonium. He was averse to operation at the time, and returned home, where, under rest, careful catheterism, the use of salol and boracic acid, and the regulation of his diet, he improved considerably and felt fairly comfortable for about a year. He again consulted me in October, 1895, on account of the symptoms recurring with greater severity. I then sounded his bladder, detecting a calculus behind the prostate. By the rectum the prostate was felt to be enormously enlarged, and there was a thickened feeling over the region of the right ureter.

Operation having been decided on, I performed suprapubic cystotomy, removing a lithic acid calculus about the size of a pigeon's egg, which was encysted in a deep pouch behind the prostate. As it was manifest that the enlarged middle lobe of the prostate would continue to obstruct the exit from the bladder, I removed it by means of the ring-cutting forceps, after removing by scissors and forceps a wedge of prostatic tissue, so as to make the bottom of the bladder pouch level with the entrance to the urethra. Considerable hæmorrhage followed, which was controlled by washing out the bladder with tincture of hamamelis (half an ounce to the pint of boracic lotion) used as hot as the hand could bear it. The bladder was drained. The patient made an uneventful recovery, and was discharged at the end of six weeks, the opening into the bladder having healed, and urine passing in the natural way, at regular intervals, and without pain. Ten months after operation the patient came to see me, expressing himself as being in the best of health, having gained 2 stones in weight, and having no difficulty or discomfort of any kind. On two occasions only had he to use the catheter, these within a month after leaving the surgical home.

REMARKS.

The fashion has for a time turned from prostatectomy to